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A SECOND YEAR'S EXPERIENCE WITH NON-RESTRAINT IN THE TREATMENT OF THE INSANE

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In 1794 Pinel removed the chains from the insane patients in the Bicêtre. At about the same time, or a little later, the Retreat at York was built and placed under the superintendence of William Tuke. Here the patients were treated with very little restraint; but neither of these went so far as to entirely abolish restraint apparatus; it was reserved for Charlesworth to attempt and for Gardiner Hill to carry it out at Lincoln, to be followed by Conolly at Hanwell, who confirmed its practicability and advantages on a large scale. Hanwell had at this time 800 patients. It is of interest to follow the various arguments which were then used by superintendents and others against the non-restraint system, and the numerous misrepresentations which were made as to the use of non-restraint by Dr. Conolly; but in spite of these unjust criticisms, which were either intentional or due to that peculiarity of the human mind which causes it to oppose whatever is new, one by one the English superintendents adopted it, and to-day in Great Britain it is the almost universal practice.

The superintendents of American asylums have almost unanimously decided to defend the use of restraint apparatus, and to-day they use the same arguments and derisive sneers against non-restraint as were used in England in the days of Conolly. They fail to see that these arguments availed nothing in opposing the spread of the non-restraint system in Great Britain.

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These superintendents say of an asylum or asylums which carry out non-restraint, "That they do not do it; it is a myth"; and feel perfectly satisfied that they have demolished the whole practice of non-restraint and its advocates.

I cannot avoid quoting from Conolly, for his remarks are so pertinent and applicable, and give exactly the arguments used to-day by superintendents. He says: "One general error seems also to pervade the minds of those who most severely condemn the abolition of restraint; they always assume that if one kind of violence is discontinued, some other kind of violence is substituted for it."

They also affirmed that the patients were locked up in cells, etc. It was at this time also that originated among these opponents of Conolly the appellation of "chemical restraint," and which they claimed was the substitute for mechanical restraint. To-day, as then, the "chemical-restraint argument" is being constantly used. If non-restraint is and can be carried out in one or more asylums, that fact is sufficient answer to all objections of quibblers. And, if it is carried out, who could possibly question which is the better, the asylum with non-restraint, or the one with restraint?

It is now two years since the adoption of non-restraint in the Kings County Insane Asylum, and from the experience during that length of time, the following has been found to be the difficulties to be surmounted and the advantages to be gained by carrying it out. The difficulties in the commencement are the prejudices on the part of attendants and others, against the abolition of restraint. Attendants who have been brought up in asylums where restraint has been carried out, are usually unable to understand how patients can be managed without, and they will even oppose it, and tell the medical officer that it is impossible; and if he still persists in his efforts to get the patient out of restraint, they will fraudulently try to convince and show him that it is impossible. They will even in certain cases go so far as to aid and urge the patient to do violence to other patients, or irritate them so as to cause great excitement, and thus carry their

point, and show the medical officer that he is wrong and they right. I have known this to be done, and it is sometimes not difficult to convince medical officers in this way. An attendant who shows the least desire to frustrate any plans of a medical officer should be immediately dismissed ; and nothing short of that will do at the outstart, for one bad attendant will spoil many.

Having restraint apparatus in an asylum has to a certain extent a demoralizing influence upon medical officers as well as attendants. Whatever difficulties may arise, there at once appear before them visions of camisoles, muffs, straps, etc., hanging on pegs ; and it is so very easy to solve the difficulty and save an immense amount of trouble and mental perplexity to the medical officers, that they order the attendant to put on the camisole. This also suits the attendant, for he, to be sure, has a struggle with his patient, but he gets him in the camisole, and then very often thrusts him into a room and is rid of him.

If there is no restraint apparatus the medical officer is obliged to go to his patient and find out what has been the cause of his excitement, and learn all the surrounding circumstances, and from this to find a way of managing the patient.

One of the great difficulties, especially with old attendants who have been brought up in asylums, is, to prevent and make them understand not to interfere with patients unnecessarily ; for instance, take a comparatively quiet ward, as you go through you will find the attendant making the patients all sit down in rows against the wall. And I have even seen one superintendent walk through his ward when all his male patients were sitting in this way ; one of them quietly arose from his seat, when he was at once pushed by the medical officer himself into it again.

This disposition to interfere unnecessarily with patients can be seen in its mildest form by any one as they pass through an asylum, even when accompanied by a medical officer. The patients arise and walk toward you ; observe now the attendant trying to make them go away and sit down ; this is very hard to make attendants believe they must not do. Two motives appear to actuate them in this : 1st, out of deference to the medical officer

who, they think, does not wish them to be disturbed; or, 2d., because of the evident fear which some people display in passing through the wards of an asylum, and which is due to the common idea that an insane person is like a wild beast.

Take another example, an excited man with chronic or acute insanity. He is in a ward walking up and down excitedly, perhaps talking loudly: the attendant follows him about: he goes into a bedroom; the attendant pulls him out: he goes to the hall door, perhaps tries the knob, or kicks the door; attendant rushes after him and pulls him away: he goes to the window; attendant thinks he is going to try and break out, takes him away from there and tries to make him sit down: each effort of this attendant has been making the patient more and more angry, and at last he strikes the attendant; he is put in a camisole after a great deal of struggling, and is hereafter looked upon as a bad man. Now all this might have been obviated and the camisole unnecessary if the attendant had only let this man alone; patients should only be interfered with when they are doing injury to themselves or others, or destroying furniture, etc.

This idea that patients must be followed about and put in restraint apparatus if they manifest the least excitement of manner, etc., so dominates the minds of attendants and others in charge of asylums that it is hard for them to believe that patients can be managed otherwise.

This is shown by a recent experience. The clerk to the Kings County Asylum, Mr. Edward Shannon, recently took eight patients to the asylum at Binghamton. Several of them were cases of chronic mania. One of them was particularly talkative and demonstrative, constantly moving about, talking in loud voice, gesticulating, etc. This man had never been in restraint (he had been in the asylum for a year and a half). These eight men were taken to Binghamton without any restraint apparatus by Mr. Shannon, in company with Dr. Hoyt (the patients were State paupers). On the way, patients from other asylums came on the train, and these patients all wore restraint apparatus, although they were cases of senile dementia and quiet terminal dementia. On ques-

tioning the persons who accompanied these patients, Mr. Shannon was told *that they were quiet patients, but they thought it was best to put them in restraint.*

Here was a marked contrast—one group of patients noisy, talkative, demonstrative (but harmless), without restraint apparatus; the other group quiet, feeble, demented, inoffensive, all in restraint.

With ordinary suicidal patients they can be cared for easily without restraint of camisole or crib, and prevented from committing suicide by a faithful and competent night-watch having these patients under observation all night. They are generally quiet, and if in sight will not try to injure themselves; but it sometimes happens that you meet with a patient who makes continued efforts of all kinds to commit suicide. In the two years that non-restraint has been carried out at the Kings County Asylum one such patient has been met with. She made many suicidal attempts. She would try to suffocate herself in a straw bed; she would cover her head with her blanket in the presence of nurse, and try to strangle herself with her hands; she would strike her body on the floor, strike her head against any thing that was hard—wall, floor, bedstead, etc.; tried to pull her tongue out and bite it off. She had advanced phthisis, extensive laceration of cervix, and atresia vaginæ of recent origin, the result of sloughing of vagina at a very recent labor. These are very difficult cases to manage, as it is almost impossible to prevent them from bruising themselves, no matter what means you employ. The camisole would not prevent such a patient from striking her head against the wall, etc.; the crib would be as useless, for they could strike themselves against it. The padded room, with watching of attendant, appears to be the best method of caring for such a patient. Fortunately these very trying cases are not frequently met with.

Seclusion of patients (that is, removing a patient to a room and locking the door so as to retain him there against his wish) is a method which can very easily be abused, unless special care is exercised; and it is true that it may be made to take the

place of another abuse, namely, restraint apparatus. The seclusion of patients must be kept under the control of the assistant medical officers, supervised by the medical superintendent, and this seclusion should be discontinued just as soon as it is possible to do so. Attempts should be made from time to time to keep the patient out in the hall. In this way you are less likely to keep the patient in seclusion longer than is necessary. In an asylum which is not over-crowded it is much easier to get along without seclusion, or with a very small amount, than in one very much crowded ; for, as a rule, seclusion has to be resorted to for preventing a patient from injuring others.

It is hard to conceive how any one can prefer the use of the camisole to seclusion. If one who has seen them both used asks himself which of these two methods he would rather have applied to himself, I think he would be very apt to prefer a temporary locking up in his own room. Besides, a man who is violent and excited, with a camisole on, can walk up and down the hall among his fellow-patients, and, if disposed, can do them just as much damage as if his hands were free, because he can and will kick them just as much as he pleases. In a room he cannot do this.

It is sometimes said by persons visiting an asylum without restraint apparatus that the patients in this asylum are not the same kind which are found in another asylum where restraint apparatus is used. This is a very great error, and if any one has seen for some length of time both methods of management, he will become convinced of it.

The truth is that the patients do really differ as far as their conduct is concerned, but no farther. They are probably all of the same nationalities and come from the same walks in life, but in the asylum without restraint the patients are quieter and better behaved, simply because they have not been and are not irritated by restraint apparatus. And a patient first admitted to an asylum and put in restraint can soon become a violent patient from this cause alone.

And it is in this way that the asylum with restraint, from its method of management, forms the violent character of its patients;

and it is in this alone that the patients in the two asylums differ. One irritates the patients with restraint, and the other does not.

This is very clearly shown by Dr. McDowall in a review of an article by Dr. Billod, published in the *Journal of Mental Science*, Jan., 1882, page 596. He says Dr. Billod is right when he says that the use of restraint is simply a matter of asylum organization. "Of this I had a crucial example during my visit to Denmark three years ago. On the island of Zeeland there are two asylums, and they are managed on entirely different principles. Both are conducted by thoroughly competent men, who devote themselves heart and soul to their work, and who carry out their ideas of right with great consistency. Yet the contrast between the establishments is surprising. At Roskilde Dr. Steinberg carries out the practice of non-restraint, and as one walks through the wards and grounds one is at once reminded of asylums as they are at home.

"Seclusion is rarely used, and restraint almost never. This asylum receives most of its patients from Copenhagen. The cases are largely composed of general paralytics and acute maniacs, due to alcohol.

"An entirely different system of management prevails at Vortenburg, a large asylum for the rest of the island. The management is perfect in its way, but it is thoroughly French. If on admission a patient is excited and destructive, he is secluded and restrained until the excitement disappears.

"I therefore saw a patient in every single room in the asylum, and some had been in these rooms from a few weeks to more than twenty years. It must be stated that the single rooms are much better than those in English asylums,—large airy rooms with windows in the roof. Across these windows it is possible to draw blinds to limit the amount of light admitted. Dr. Fürste found that the amount of light influenced the excitement; the more light the more excitement. There were strait waistcoats in abundance. It must not be imagined that all this restraint and seclusion are employed to save trouble. They are employed on principle as the best method of treatment.

"The staff is large—one attendant to six patients—and the supervision by the superior officers thorough and untiring. Dr. Fürste spends far more time in the wards than any English superintendent I know—on an average ten hours a day; he is evidently popular with his patients, many of whom told me that they are very kindly and considerately treated. In spite of all this I could not help condemning a system which locks up patients for years, and I can never forget the case of an old woman, an amusing chronic maniac, who had not seen the sun or a blade of grass for more than twenty years.

"My Danish experience settled the matter to my mind. Without denying the influence of racial and other difficulties, it is certain that there is no absolute obstacle to the adoption of the non-restraint system."

It has also been claimed now, as in the days of Conolly, that with the abolition of restraint apparatus there was instituted to take its place the use of sedative drugs, and which was styled "chemical restraint." Conolly denied this, and to-day we have the best argument against this fallacy, in the tables in Dr. Wilbur's article showing the relative amount of sedatives used in the asylums with restraint and those without. Dr. Wilbur's tables are here reprodued (see ARCHIVES, vol. vi, p. 271).

TABLE NO. I.—BRITISH ASYLUMS.

NAME OF ASYLUM.	No.	Number of patients	Monthly occasions of restraint.	Monthly number restrained.	Monthly occasions of seclusion.	Monthly number secluded.	Average number to whom chloral is daily adminst'red.	Av'rage number to whom hyoscyamia or other narcotic is administered to allay excitement.
West Riding Asylum . .	1	1,410	1	1	2	2	31	38
County Asylum, Chester .	2	533	None	None	None	None	None	4 Morphia used occasionally
Hull Borough Asylum . .	3	163	"	"	"	"	1	2
Montrose Roy'l Lun. Asl.	4	485	"	"	19	1	3	1
Brookwood Asylum, Surrey	5	1,050	"	"	None	None	10	1
East Riding Asylum . .	6	285	"	"	"	"	½	None
Hanwell Asylum	7	750	"	"	"	"	None	"
Burntwood Asl., Litchfield	8	600	"	"	"	"	"	"
Royal Edinbur'h Asylum .	9	832	"	"	20	"	1	"
North Riding Asylum . .	10	546	2	1	3	"	7	9
Royal Asylum, Gartnavel .	11	483	None	None	None	None	6	14
Richmond Dist. Asl., Dublin	12	1,013	"	"	3	1	11	2
Dr. Hill's Norfolk Co. Asl. .	13	620	"	"	None	None	None	20
Kent Co. Asylum . . .	14	1,200	"	"	"	"	"	None
Woodilee, near Glasgow . .	15	448	"	"	"	"	"	"
		10,419	3	2	47	4	70½	91

TABLE NO. 2.—CANADIAN ASYLUMS.

Name of Asylum.	No.	Number of patients	Monthly occasions of restraint.	Number restrained.	Monthly occasions of seclusion.	Number secluded.	Average number to whom chloral is daily admins't'red.	Av'rage number to whom h yosc yami a or other narcotic is administered to allay excitement.
Nova Scotia Hos. for Insane	1	380	117	11	17	5	None	None
Lond. Ont., Asl. for Insane	2	851	61	8	13	9	"	"
Toronto Ont. Asl. for Insane	3	673	10	3	4	2	2	3
Hamilton Ont. Asl. for Ins.	4	537	6	—	4	—	5	5
Kingston Ont. Asl. for Ins.	5	430	4	—	13	—	occa-sional	occasional
		2,871	198	—	51			

TABLE NO. 3.—ASYLUMS IN UNITED STATES.

Name of Asylum.	No.	Number of patients	Monthly occasions of restraint.	Number restrained.	Monthly occasions of seclusion.	Number secluded.	Average number to whom chloral is administ'red daily.	Av'rage number to whom hyoscyamia or other narcotic is administered to allay excitement.
Northern Hospital, Wis.	1	541	48	—	1	1	24	8 daily
Cook County Asylum, Ill.	2	440	480	—	60	—	33	—
Kings County Asy'm, N.Y.	3	868	None	None	—	8	5½	6 a month
Wooster Hospital, Mass.	4	594	69	—	71	—	22	No record
Retreat for I'sane, H'rtf'd, Ct.	5	121	2	—	2	—	4	1 daily
Willard Asylum, N. Y.	6	1,727	—	6 daily	7	—	27	10 daily
Athens Asylum, Ohio	7	586	None	None	116	58	20	None
Longview Asylum, Ohio	8	661	8	—	11	—	8	1 daily
Dayton Asylum, Ohio	9	591	118	6 daily	309	—	29	—
Northern Asylum, Elgin, Ill.	10	526	483	—	25	—	26	5 daily
Insane Crimin'l Asy'm, N.Y.	11	131	1	1	—	—	1½	5 a month
Middletown, Conn.	12	582	16	3	43	15	21	1 daily
Minn. Hospital for Insane	13	530	67	43	24	17	6	2
Southern Asylum, Anna, Ill.	14	486	350	—	129	—	12	3
Eastern Illinois Asylum	15	175	—	1	22	—	—	3
Homœopathic, N. Y.	16	244	5	3 daily	—p	—	None	None
Central Hospital, Illinois	17	641	483	32	2	—	73	48
Western Asylum, Kentucky	18	473	16	—	12	—	9	8
Hudson River Hospital	19	250	—	6	None	—	29	12
State Insane Hospital, Wis.	20	548	2,547	—	13	—	4	10
Danvers, Mass.	21	643	138	—	161	—	5	3
Northampton, Mass.	22	471	292	25	248	26	None	None
State Lunatic Hospital, Harrisburg, Pa.,	23	353	3	—	21	—	18	3
Taunton Lunatic Hospital	24	574	14	—	6	—	20	—
N. J. S. Lunatic Asylum	25	583	180	—	150	—	118	None
Newburg, Ohio	26	625	24	—	38	—	47	21
	—	13,967	—	—	1,254	—	561	139

This table is incomplete in some of its columns because the reports upon which it is based were imperfect.

I have reason for believing that since these tables were drawn up by Dr. Wilbur, an improvement has taken place in these asylums. J. C. S.

Asylums with restraint use as much of sedatives if not more than those having no mechanical restraint. If this were a correct argument, the asylums without restraint should use a great deal more than those with restraint, which they do not.

The use of the words "chemical restraint" for the administration of sedatives to excited patients is incorrect. Within the proper limits which govern the giving of sedatives, and in fact all medicines, it is justifiable, even proper and necessary, to give sedatives to an excited insane person, as to give opium to a person in physical pain or suffering from peritonitis.

Any one who says that it is unjustifiable to give a man sedatives who is suffering from terrifying hallucinations from excessive use of alcohol, for instance (even if they be of temporary effect), while in connection you give him large quantities of food, etc., for the purpose of restoring him to his normal condition, simply talks nonsense. And it must never be forgotten that a great deal of useless argument and criticism are indulged in by the profession on this subject of giving drugs.

The experience at the Kings County Asylum has been, that with the abolition of restraint, there has been a gradual diminution in the amount of sedatives given both by day and night, and to-day it is very small.

It has always been thought that to carry out non-restraint a large number of attendants were required; this has also been proved to be incorrect by the experience of the Kings County Asylum, where there is one attendant to fifteen patients on the average. And from recent reports of the Commissioners of Lunacy in England and Scotland, it appears that in their asylums there is on the average not more than one attendant to twelve patients.

But one of the most important points in carrying out the system of non-restraint is to find occupation for the patients. This aids very much in keeping them quiet and more contented, tends to turn their attention to a more normal train of thought, and in some cases prevents the rapid approach of complete dementia.

One great difficulty with American asylums, and it appears to be the same to some extent in England, is the want of occupation for men in winter, and the difficulty of getting both sexes out of doors in winter. The want of out-door exercise and recreation causes a restlessness, and makes it much more difficult to get along with them. It is hoped that a solution of this will be found erelong.

It must not be inferred that restraint apparatus is used to great excess in all the asylums in this country. There are certainly a great many where it is carried to its fullest extent (see article by Dr. Woodside in *N. Y. Medical Record*, March 4, 1882); but it is gratifying to learn from gentlemen well acquainted with many asylums that there has been a diminution of the use of restraint apparatus within recent times, and doubtless this will continue following the same course as it did in Great Britain.